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Prevention of Domestic Violence

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Abstract: **Domestic violence (DV) is an epidemic affecting women in our nation regardless of age, race, economic status, nationality, religion, or educational background and is often overlooked, denied and even excused. When Health Care Providers notice and acknowledge the warning signs and symptoms, reporting is necessary. The Health Care Provider's knowledge level regarding signs and symptoms of domestic violence influences the success of reporting any suspicious behaviors to appropriate departments for future investigation. Domestic violence is defined as behaviors used by one person in a relationship to control the other resulting in physical or psychological injury. Partners can be married or not married, lesbian, gay, heterosexual living together, separated or dating. The consequence of DV results in a decline of economical, social, psychological, spiritual, and emotional well-being of victims and is the major factor that contributes to morbidity and mortality among women (World Health Organization (WHO), 2009). Using evidence-based practice, the author presents a systematic in-depth review investigating the relevant studies and doing preliminary literature searches that can answer the question:"Does the assessment of domestic violence help to disclose the act of DV in women population?"**

Keywords: **domestic violence, prevention, assessment, research, intimate partner violence, screening, victim psychology, statistics.**

1. INTRODUCTION

Domestic violence (DV) refers to a wide range of physical, sexual, emotional and financial abuse of people who are, or have been, intimate (married or cohabiting) partners (WHO, 2009). Domestic violence is a social problem that has important healthcare implications. DV impacts on the mental and physical health of individuals, creates financial issues, and causes harm to families and children. The concepts reviewed by author are the effectiveness of routine screening for domestic violence at each visit done by the Health Care Providers and the responsiveness to such screening.

The population of interest was adult battered women that experienced at least one domestic violent act (abuse, neglect, and exploitation). Literature suggests that domestic violence assessment is an effective tool that Health Care Providers can use as an intervention to increase the disclosure of abuse in women, implement a plan of actions, and decrease future episodes.

2. CRITERIA FOR INCLUSION

The process of getting knowledgeable research articles in the field of Domestic Violence uses a standard methodology of reviewing articles in the field of Domestic Violence (Melnyk & Fineout-Overholt, 2005). A search of articles published between 2004 and 2011 was conducted using CINAHL, PubMed, and Cochrane Library databases. Keywords for the search included: *domestic violence, women, healthcare, adult, victim, disclosure, intimate partner violence*.

The review included articles that were limited to those written in English. The search returned 89 studies focusing on DV and an extensive research was initiated to locate the randomized controlled trials (RTCs). Additional databases were assessed via the West Virginia University Morgantown Library website using databases including EbscoHost, Academic Search Complete, CQ Researcher, Encyclopedia Britannica, Google Scholar, and Journal of Nursing Research for articles and studies of interest. Five recent randomized controlled clinical trials (RCT's) were chosen for inclusion in this review

based on the subject adult women experiencing domestic violence. The review focuses on research of *women* victims (aged over 18 years) who experienced domestic violence.

3. LITERATURE REVIEW

Estimates of the domestic violence prevalence in the United States indicate more than 1 to 4 million of women are abused by their partner each year, and the prevalence rate is 44% over a lifetime. Emergency departments annually present with 2-5% of woman with acute injuries as a result of violence (WHO, 2009). Domestic violence is the major contributor to the injury of the physical and psychological health of victims causing enormous consequences on mental developmental. Healthy People 2020 include objectives that provide support for those who work to prevent violence and help victims with housing, transportation, financial assistance, social consult, and health care (National Institute of Justice (NIJ) & Center for Disease Control and Prevention (CDC), 1998).

In their study Hegarty et al. (2010), shows that there is sufficient evidence to justify screening programs and the implementation of a brief intervention with a positive response to women's safety and quality of life. The design was a randomized controlled trial that conforms to "Consort statement guidelines" (Hegarty et al., 2010).

The sample size of 89 women experiencing domestic violence was divided in two groups with 80% power, α 0.02 to detect clinical effect in 12 months time period. The researchers did not identify interventions fully and effectively due to barriers to such as lack of women's trust in health care providers and the fear of consequences the disclosure could bring in their life. There were only 60% of women who brought the desire to disclose and listen to alternative interventions. Recruitment included woman from urban and rural areas screening positive for domestic violence, stress, and depression (Hegarty et al., 2010).

The study determined that the screening for domestic violence was influenced by a health care provider's knowledge level of domestic violence education. Nurses and physicians are the first Health Care Providers that come in contact with patients that experience such act as domestic violence, and the potential barriers to screening are the knowledge level on how to screen for domestic violence, the environment, and language used during assessment (Hegarty et al., 2010).

According to McMillan et al. (2009), the domestic violence assessment does provide sufficient evidence to support the screening in the health care settings. A group *n*=3271 of women were screened and found to be positive for domestic violence experience with the Abuse Screening Tool (WAST). The settings for this stud were emergency departments, primary care, and obstetrics/gynecology setting.

After the intervention 43% of women (modeled odds ratio 0.82, 95% confidence interval, 0.32-2.12) were followed-up and after 18 months n=411 (3.74; 95% confidence interval, 0.47-7.00) observed recurrence of abuse which implies the effectiveness of screening tool at α 0.05 level 80% power. Due to its limitation, the study requires caution in interpretation of the trial results. One example is validity of disclosure. The same results are found in Hegarty et al. (2010) that suggest the need for adequate domestic violence training to recognize the appropriate sign and symptoms of violence.

Rhodes et al., (2006) found that computer screening increases but did not guarantee the disclosure of domestic violence among women coming to an emergency department. Women in this study were recruited from both urban and rural areas. The results in urban area were 56%, p=0.04 and rural area the disclosure were only 14% p=0.07 revealed that suburban women and those with private insurance and higher education were less likely to be screened. The result shows that computer screening increases DV disclosure and that needs to be considered the immediate safety of patients after the disclosure (Rhodes et al., 2006).

Assessing in clinical practice is important as the proportion of women seeking medical assistance as a result of abuse is estimated to be between 8% and 39%. The guideline suggests that screening needs to incorporate questions into a routine health history process (Bureau of Justice Statistics, 2007). Health Care Providers need to consider the immediate safety of women that experience such acts by implementing a plan of care with adequate referrals (Rhodes et al., 2006).

In the first European randomized controlled trial study Gregory et al. (2010) states that the intervention to improve the health-care reaction to violence is interdependent by collaboration between Health Care Providers and third sector agencies specialized in domestic violence. The results showed that referral to domestic violence advocacy personnel reduced the violence and improved mental health, and the quality of women's lives. One important aspect during screening is the privacy and the environment when face-to-face questions are asked (Gregory et al., 2010).

The screening should be done with patients alone without the presence of their partner/member family. If barrier languages are present practitioners should use only trained cultural interpreters. Because many women do not disclose abuse the first time they are asked, screening women for abuse should not only occur on the initial health history but also each time the health history is updated (Gregory et al., 2010).

A similar study was done by Kiely, El-Mohamed, El-Khorazathy, and Ganz (2010) that screened pregnant women experiencing domestic violence and the results showed that a relatively brief intervention during pregnancy had positive effects on pregnancy outcomes. Women randomized to the intervention were less likely to have recurrent episodes (OR= 0.48, 95%CI=0.29-0.08) and fewer women had preterm infants (p=0.3) and an increased mean gestational time frame (p=0.016) (Kiely et al., 2010).

The efficiency of the screening varied, depending upon the health care setting, the trust relationship of the professional to the woman, the presenting problem, and the patients' history. The victims were concerned about the screening process, and some of them felt that the healthcare professional's response to disclosure was unhelpful. The study concluded that victims did not necessarily consider the healthcare environment the best place to express the disclosure of domestic violence (Kiely et al., 2010).

According to MacMillan et al. (2009), there is a need for a supportive and non-judgmental approach to screening fostered by an environment openly displays materials to inform women of the staff's willingness to discuss abuse. Furthermore, if the victims do not collaborate and do not have trust in the referral offered the prevention and eradication of future violence are not resolved (Rhodes et al., 2006).

Both studies suggest that domestic violence assessment and intervention is not enough and that Health Care Providers should be aware that safety is never guaranteed, and even a detailed safety plan does not ensure the end of violence. The victim that experienced violence is the only one who can eliminate the risks, and the likelihood of further violence (Fox & Zawith, 2007). The strength of MacMillan et al. (2009) study is based on a large size sample using women from a variety of clinical practice that minimized the bias. The abstract was strong formulated, clear and concise including well-formulated objective and methodology. The limitation was the lack of any theoretical framework used in the study. Despite any identified limitation the researchers summarized the results with tables and figures (MacMillan et al., 2009).

Data collection in Kiely et al. (2010) study consisted in operational and conceptual definitions that were congruent. The results are clear formulated suggesting that psycho-behavioral intervention decreases the health consequences of pregnant women experiencing domestic violence. The strengths included the use of validated instruments for each data collection using logistic regression to the model intimate partner violence (IPV) victimization recurrence (Kiely et al., 2010).

The pregnant women who adhered to the study were randomized to the cognitive- behavioral intervention based on the Conflict Tactics Scale (CTS). The mothers in the study encountered other behavioral challenges during the study. The limitation was the lack of power to test the efficacy of the intervention. The methods used appropriate procedure, and the study was approved by institutional review board of all participating institutions (Kiely et al., 2010).

The strength of Gregory et al. (2010) study consisted of a valid and widely accepted measurement of domestic violence, the data collected with electronic medical records based on HARK over two times periods, and the intervention supported within educational Adult Learning Theory. The results were consistent addressing each research question using appropriate statistical methods (IRIS). The weakness of the study was the lack of cost-effectiveness of the intervention (Gregory et al., 2010). Rhodes et al., (2006) used in their study the audio taping that has the advantage of providing direct evidence but creates participant's bias. Audio taping caused Hawthorne effect due to unblinding of the intervention and treatment diffusion. Despite these limitations, the study's findings appear to be valid and represent meaningful evidence to the nursing practice.

Hegarty et al. (2010) strengths consist in CONSORT guideline used, a broad cross-section size minimizing bias, and the intervention /comparison used in one general practice to reduce contamination of cross-over effect. The study is ethically approved by Human Research Ethics of Committee of the University of Melbourne. Data collection represents the weakness that lacks "blinding" due to the intervention (professional training plus patient counseling). The sense of safety, nature/frequency of abuse, health status, safety behaviors, post-traumatic stress disorder, self-esteem, and social support were variables measured and included in 6 to 12 months of surveys. The researcher did an evaluation of any incremental cost-consequences analysis and incremental cost-effectiveness analysis.

4. METHODOLOGY

The review synthesized data using thematic analysis and followed Melnyk and Fineout-Overholt (2005) that suggests the use of a larger a sample size tends to decrease/eliminate the bias of the study and increase the confidence in the answering of burning clinical questions. Data were summarized for the effects of expectation and perceptions of all five studies that addressed the screening and the prevention of domestic violence.

Practitioners are often times the first persons an abuse victim comes in contact with and therefore an appropriate and focused nursing response is very critical to the treatment and services provided to the victim (WHO, 2009). All five studies came to same results the need for routine screening and further referrals to promote a plan of care for health and healing, to prevent disease, illness, injury, and further acts of domestic violence.

Results of all five study indicated that it is very important to identify the act of domestic violence in order to prevent further abuse and injury. Furthermore, there are barriers to application of a successful assessment in practice. There are no contradictions between studies. The quality of all five studies is represented through credibility and cogency, the lack of confirmation was not carry out, and the need for further evaluation needs to be done in future reviews. According to McMillan et al. (2010), the limited domestic violence training of Health Care Health Care Providers, the lack of comfort, fear of offending, powerlessness, loss of control, and time constraints were some of the barriers. Professional in the ability to identify and successful treat women that experience domestic violence accounts for further changes (Hegarty et al., 2010).

The studies conducted by Gregory et al. (2010) and Kiely et al. (2010) support the need for domestic violence assessment of women in clinical practices and the referral to domestic violence advocacy to improve the health care of women and decrease future domestic violence episodes. The researchers in both studies used a descriptive synthesis and an appropriate discussion about the need for supplemental domestic violence education of health care providers that assess women their practice. This suggestion was supported by Hegarty et al. (2010) and Rhodes et al. (2006) who stated that screening for domestic violence during each history and physical examination of women increase the disclosure of domestic violence of women.

5. DISCUSSION

All five studies covered a wide range of services and settings including primary care, acute care departments, domestic violence intervention or support services, and mental health institutions. The findings in these studies identify assessment of domestic violence and implementation of a psycho-behavioral intervention of women that experience domestic violence the key factor in decreasing the consequences. The purpose of domestic violence identification is to ensure that victims who may need referral to support services and additional assistance are identified and addressed immediately (Kiely et al., 2010; Hegarty et al., 2010; McMillan et al., 2010; Rhodes et al., 2006).

The data collected in all five studies is examined using many interpretations in order to find linkages between the research variables and the outcomes with reference to the original research questions. Throughout the evaluation and analysis process the researchers remain open to new opportunities and insights. The feasibility is relative and determines that the studies are clinically significant with strong statements and recommendations. All five studies does recommend including the domestic violence assessment in an individualized manner based on each female client to each clinical practice.

The literature review summarized an improvement of women's health followed by domestic violence disclosure. The outcome is influenced by the type of exposure to domestic violence: emotional, social, cognitive, behavioral, cognitive, and general health functioning (Kiely et al., 2010; Hegarty et al., 2010; McMillan et al., 2010; Rhodes et al., 2006). Moreover, there are relatively few empirical studies with adequate control of confounding variables and a sound theoretical basis. Due to heterogeneity within each of these groups age, sex, and type of outcome were not significant moderated.

6. GAPS AND FUTURE DIRECTIONS

In their report, Klevens and Saltzman (2009) suggested that new domestic violence training methods are needed for Health Care Providers. The U.S. Preventive Service Task Force (USPSTF) concluded there is sufficient evidence to recommend routine screening for domestic violence in clinical practices. Due to huge limited time constraints, Health

Care Providers have to assess and diagnose patients regarding domestic violence, it is important to have an increased knowledge of signs and symptoms of domestic violence. Many times, patients with domestic violence issues present in the office with numerous clinical complaints like a migraine headache, loss of appetite, stomach ulcers, constipation, abdominal pain, depression (Klevens & Saltzman, 2009). Moreover, over the last few years, numerous states mandate minimum continuing education in domestic violence as a requirement for licensure (CDCP, 2006).

Furthermore, Stinson & Robinson (2006) showed a need for increased knowledge for health care providers about modalities to assess and document domestic violence in the last decade. Educators in nursing education programs developed new strategies to eliminate this gap by introducing additional information in the curriculum about methods to recognize the act of domestic violence. This provides additional knowledge for nurses in assessing the specifics of each domestic violence situation as a means of decision-making about whether it is necessary to make a report (Gregory et al., 2010).

There is a wide range of studies in the literature that supports the results found in this review. Clinical evidence suggests that screening for domestic violence has a positive impact on its disclosure and the level of domestic violence. The trust relationship between the nurse and these women will help to increase disclosure and the acceptance of further referral (Stinson & Robinson, 2006).

Disclosure of domestic violence is mandatory by law to be reported to the authorities and requires additional training in assessing the specifics of each situation as a means of decision making about whether it is necessary to make a report. The disclosure of a potential act of violence can be done by practitioners using a domestic violence assessment during the admission assessment. When disclosure of such act occurs as a result of a nurses screening, during the evaluation, nurses have the right to investigate further and report, and efficient response must follow (HIPPA HHS, 2008).

7. CONCLUSION

Domestic violence is a behavior that causes damage and brings many chronic health problems to survivors. There is an urge for future studies research about the effect of domestic violence assessment on women's physical and mental health. Using evidence-based practice, the review concluded that abuse is not recognized and appropriately treated by practitioners and that there is an increased need for domestic violence training of Health Care Provider to identify the sign and symptoms successfully.

The keys factor to successful disclosure there is ongoing domestic violence assessment, the physician/nurse-women trust relationship, and an adequate environment during screening for domestic violence. Nonetheless, there is a need for future studies that will improve the quality of women who experienced domestic violence by implementing an individualized plan of referrals in clinical practice.

REFERENCES

[1] Bureau of Justice Statistics (BJS). (2007). *Crime characteristics.* Retrieved from http://www.ojp.usdoj.gov/bjs

[2] Campbell, J., C. (2005). Assessing dangerousness in domestic violence cases: History, challenges, and opportunities. *Criminology and Public Policy, 4*, 653-672

[3] Centers for Disease Control and Prevention (CDCP). (2006). *Intimate partner violence: Fact sheet.* Retrieved from http://www.cdc.gov/ncipc

[4] Department of Health and Human Services (DHHS). (2004). *Domestic Violence Perpetrator Assessment Tool.* Retrieved from http://info.dhhs.state.nc.us/olm/forms/dss/dss-5234.pdf

[5] Fox, J. & Zawitz, W. (2007). *Homicide trends in the United States.* Retrieved from http://www.ojp.usdoj.gov/bjs

[6] Gregory, A., Ramsay, J., Agnew-Davies, R., Baird, K., Devine, A., Dunne, D…. & Feder, G. (2010). Primary care identification and referral to improve safety of women experiencing domestic violence (IRIS): Protocol for pragmatic cluster randomized controlled trial. *BioMed Central 10*:15.

[7] Hegarty, K., Gunn, J., O'Doherty, L., Taft, A., Chondros, P., Feder, G., Astbury, J. & Brown, S. (2010). Women's evaluation of abuse and violence care in general practices: Cluster randomized controlled trial. *BMC Public Health 10*:2.

[8] HIPPA HHS Regulations. (2008). *Disclosures about victims of abuse, neglect or domestic violence.* Retrieved from http://www.csosa.gov/about/policies/docs/4012_disclosure_to_authorities.pdf

[9] Kiely, M., El-Mohamed, A., El-Khorazathy, M. & Gantz, M. (2010). An integrated intervention to reduce intimate partner violence in pregnancy: A randomized controlled trial. *NIH Public Access 115*: 273-283.

[10] Klevens, J. & Saltzman, L. (2009). Controversy on screening for intimate partner violence: A question of semantics? *Journal of Women's-Health.*

[11] MacMillan, H., Wathen, N., Jamieson, N., Shannon, H., Ford-Gilboe, M., Worster, A….& McNutt, L. (2009). Screening for intimate partner violence in health care settings: A randomized trial. *JAMA 302*:493-501.

[12] Melnyk, B., & Fineout-Overholt, E. (2005). Evidence-based practice in nursing & healthcare: a guide to best practice. *Philadelphia: Lippincott Williams & Wilkins.*

[13] National Institute of Justice (NIJ) and Center for Disease Control and Prevention (CDCP). (1998). *Prevalence, incidence, and consequences of violence against woman: Findings from the national violence against women survey*. Retrieved from http://www.nij.gov/pubs-sum/172837.htm

[14] Rhodes , K., Drum, M., Anliker, E., Frankel, R., Howes , D. & Levinson, W. (2006). Lowering the threshold for discussions of domestic violence: A randomized controlled trial of computer screening. *American Medical Association*, 166.

[15] Stinson, C. & Robinson, R. (2006). Intimate partner violence: continuing education for registered nurses. *J Contin Educ Nurs; 37*(2):58-62.

[16] World Health Organization (WHO). (2009). *Reducing violence through victim identification, care, and support programs.* Retrieved from http://whqlibdoc.who.int/publications/2009/